Lucas County Health Benefits

Open Enrollment Form

Section I - Employee Information and Instructions **Employee ID** _____ **Department ID** _____

Department Name _____

Please mark (☐) appropriate box and circle appropriate response

EFFECTIVE DATE _____

☐ New Employee, Open Enrollment, Re-Instate

☐ Transfer of Employee

From: _____

To: _____

☐ Addition of Spouse or Dependent Name _____

☐ Drop Spouse or Dependent Name _____

☐ Drop Coverage

☐ Change Name or Address

☐ Change Other Health Care Information

☐ COBRA

☐ Change PCP

☐ Change Carriers

From: _____

To: _____

Last Name	First Name	M.I.	Birth Date	Social Security Number

Street Address	City	State	Zip	Phone (H) Phone (W)

Male / Female	Marital Status (Single, Married, Divorced, Legally Separated, Widowed)	Date of Marital Status	Tobacco Use
			Yes No

Section One (I) (above) is for your personal data. You must complete every field in this section.

Section Two (II) is for your spouse's personal information and coordination of benefits information (if applicable). Please complete all applicable fields and attach all documentation necessary (if applicable).

Section Three (III) is for your dependents' personal information and coordination of benefits information (if applicable). Please complete all applicable fields. **If you need additional dependent forms, please see your department benefits representative, or simply make the necessary amount of copies from the blank form you have been provided in this packet.**

Section Four (IV) is your benefit enrollment choices for plan year 2005. Please check the appropriate selection for each health, drug, dental, and life plan you wish to enroll in. All selections you make are binding until the next open enrollment period.

After you have reviewed the forms, please sign and date on the spaces provided and return the forms, ALONG WITH ANY NECESSARY DOCUMENTATION, to your department benefit representative no later than **FEBRUARY 4, 2005**.

If you have any questions regarding how to complete the forms, eligibility or documentation requirements, etc. please contact your department benefit representative.

Signature _____ **Date** _____

Insurance Fraud Warning:

Any person who, with intent to defraud or knowing that he / she Is facilitating a fraud against a benefits plan, submits an application or files a claim containing a false or deceptive statement is guilty of Insurance fraud.

Social Security Identification Number Consent

I, _____ _____ **, understand that reasonable use of my social security number**
Print Name **Date of Birth**

is a fundamental imperative to the correct administration of these plans and the delivery of proper medical care. I hereby authorize Lucas County to use my social security identification number to assist in benefits administration. This includes displaying the social security identification number on the benefits plan identification cards. I am not authorizing indiscriminate, unlimited or unwarranted access to my social security identification number. I hereby authorize the County to only release this number to any entity directly responsible for benefits administration or medical services delivery. If you refuse the use of your social security identification number as stated above, a separate form must be completed in order to enroll in the health plan(s).

X Signature: _____ **Date:** _____

Section II

(circle one) **Spouse - Add / Drop / Change**

Employee Name: _____ **Employee ID:** _____ **DeptID:** _____

Spouse Name _____ **Relationship** _____ **Date of Marriage** _____

SSN _____ **Birth Date** _____ **Male / Female** _____

Address _____ **Tobacco Use : Yes / No**

City, State, Zip _____ **Effective Date of Add / Drop / Change** _____

Yes	No	**Must be completed If married!** (Spouses must comply with the Lucas County Eligibility Rules.)
☐	☐	Is your spouse employed? If yes, employers name: _____
☐	☐	If yes, is your spouse ELIGIBLE for any health/drug insurance through their employer?
☐	☐	If yes, is your spouse enrolled in their employer's health/drug insurance? (If yes, please fill out the form below.)
☐	☐	Did your spouse accept cash or any other incentive to NOT enroll in their employers health/drug insurance?
☐	☐	Is your spouse required to pay 40% or more of their employers premium for the lowest cost single health plan?
☐	☐	Is your annual gross household earnings $62,000 or less? (A separate form is required to apply for a hardship appeal)

Medical

Lucas County Coverage _____ **HMO PCP** _____ **PCP ID#** _____

Other Medical Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

Dental

Lucas County Coverage _____

Other Dental Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

Prescription Drugs

Lucas County Coverage _____

Other Prescription Drug Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

Section III

(circle one) **Dependent - Add / Drop / Change**

Employee Name: _____ **Employee ID:** _____ **DeptID:** _____

Dependent Name _____ **Relationship** _____

SSN _____ **Birth Date** _____

Full Time Student : Yes / No

Address _____ **Tobacco Use: Yes / No**

City, State, Zip _____ **Physically Disabled/Mentally Retarded : Yes / No**

Is this a college address? Yes / No **Male / Female** _____ **Effective Date of Add / Drop / Change** _____

Court Order (circle one)
Yes / No
Responsible Person
_____

Yes	No	
☐	☐	Is your dependent covered on any other insurance plan? If yes, complete 'Other Coverage' sections below.
☐	☐	Is your dependent employed? If yes, employers name _____
☐	☐	If yes, is your dependent ELIGIBLE for any health/drug insurance through their employer?
☐	☐	If yes, is your dependent enrolled in their employer's health/drug insurance? (if yes, please fill out the form below.)
☐	☐	Did your dependent accept cash or any other incentive to NOT enroll in their employers health/drug insurance?

Medical

Lucas County Coverage _____ **HMO PCP** _____ **PCP ID#** _____

Other Medical Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

Dental

Lucas County Coverage _____

Other Dental Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

Prescription Drugs

Lucas County Coverage _____

Other Prescription Drug Coverage Information

Effective Date of Coverage _____ Insurance Company Name _____

Policy Holder Name _____ Policy Holder Employer Name _____

Policy Number _____ Policy Holder Employer Addr _____

Policy Holder Date of Birth _____ City, State, Zip _____ _____ _____

Relationship to Policy Holder _____ Phone _____

BENEFIT ENROLLMENT SELECTIONS

For 2005 Program Year (03/01/05-02/28/06)

Section IV

Employee Name _____ **Employee ID** _____ **Department ID** _____

Below are your medical, dental, prescription drug, and life insurance options. This year the plan year will be effective March 1, 2005 and run through February 28, 2006. After you have made your enrollment selections, please make a copy for your personal records and return the original to your department benefits representative, along with any required documentation (if applicable), no later than **FEBRUARY 4, 2005**. If you enroll in the Paramount HMO, you must designate a Paramount primary care physician (PCP) for each family member enrolled. Lucas County can not guarantee the participation of any medical, prescription drug, or dental provider under any of the medical, prescription drug, or dental plans it offers. These selections will be effective for the remainder of the plan year.

Medical

Choose only one option:

PCP Selection & ID# _____

Lucas County Health Plan	___Single	___Family	___Family with Spouse PRIMARY
Paramount HMO	___Single	___Family	___Family with Spouse PRIMARY
Waive Coverage	___		

Dental

Choose only one option:

Lucas County Traditional Dental Plan	___Single	___Family
Lucas County Dental PPO Plan	___Single	___Family
Waive Coverage	___	

Prescription Drug

Choose only one option:

Lucas County Drug Plan	___Single	___Family
Waive Coverage	___	

Life Insurance

Choose only one option: ___Enroll ___Waive

On behalf of myself and my eligible dependents, I understand that all selections I have made above are binding until the end of the plan year. If I experience a qualifying event, I must complete, sign, and return a new enrollment form to my department representative within 30 days of that qualifying event. I also understand that by applying for any Lucas County Health, Drug, Dental or Life Insurance Plan option described above, I agree to comply with the coverage provisions of the applicable Plan Documents/Group Service Agreements, and the Lucas County Employee Benefits Eligibility Rules, copies of which are available through the Lucas County Risk Management Department. I authorize the plan(s), or its designated claims administrator, to coordinate benefits and/or reimbursement with other health or insurance companies in accordance with the Plan Document and the Lucas County Eligibility Rules. I further authorize any medical provider, insurance company or any other organization to release to the plan(s), or its designated claims administrator, copies of records concerning examinations, treatments, history, diagnosis, prescription or other medical information relating to medical expenses incurred. I understand that such information and records will be used by the plan(s), or its designated claims administrator, for the purpose of evaluating and administering claims for benefits. The plan, or its designated claims administrator, may release such records for those purposes, or for the purpose of coordinating benefit payment under any Non-Duplication of Benefits Provisions to its representatives performing business or legal functions. I know that I have the right to ask for and receive a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original. I certify that all information is true and correct to the best of my knowledge. I understand if I enroll in the Dental PPO Plan that unauthorized services performed by any non-network provider will not be considered eligible expenses. Paramount is a Covered Entity under HIPAA, and is permitted to use, obtain and disclose Member Protected Health Information (PHI) to perform Paramount operations in accordance with Paramount's Notice of Privacy Practices. Under the Paramount HMO, I agree to choose a participating Paramount physician for primary care and to secure a referral from that physician for all care (except for Emergency Medical Conditions and other care approved by Paramount). If appropriate, I authorize Lucas County to deduct, from my wages, the amount required (if any) to cover any contribution or co-pay for coverage under the plan(s).

Any person who, with Intent to *defraud or knowing that he/she is facilitating a fraud against a health plan, submits an application or files a claim* containing a *false or deceptive statement is guilty of insurance fraud under Ohio Criminal Law. I certify that all the above information is correct.*

Signature Required : _____ Date: _____